STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
4500 10th Ave SE, Lacey, WA 98504

August 9, 2019
CERTIFIED MAIL
7018 0360 0000 1578 7092

Robert J Efford
Aacres WA LLC (Spokane County) #3
5709 W Sunset Hwy Suite 100
Spokane, WA 99224

RE: Aacres WA LLC (Spokane County) #3 Certification #2011185

Dear Administrator:

The Department completed a complaint investigation of your Supported Living Program on July 31, 2019 and found that your program does not meet the Certified Community Residential requirements.

The Department:
- Wrote the enclosed report;
- May take certification enforcement action based on any deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies.
- Expects all deficiencies to be corrected within the approved timeframe.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately;
- Within 10 calendar days after you receive this letter, provide a written plan of how you will correct each deficiency, according to the attached "Plan"; and
  - Sign and date the first page of the enclosed report; and
  - Return the first page with your plan; and
  - Have your plan approved by the Department; and
- Complete correction within 45 days or sooner if directed by the Department.

Plan (Plan of Correction)
You Must:
- **Send the plan within 10 calendar days after you receive this letter.**
- **Include the following in your plan for each deficiency:**
  - **What the service provider did or will do to correct each deficiency;**
  - **How the service provider will prevent problems of this type;**
  - **Who will be responsible for monitoring the corrections to ensure the problems do not recur; and**
  - **When lasting correction will be achieved.**

- **Send your plan to:**
  Nicole Vreeland, Field Manager
  Residential Care Services
  P.O. Box 45600
  Olympia, WA 98504-5600
  Fax: (360) 725-3208

You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - What specific deficiency or deficiencies you disagree with; and
  - Why you disagree with each deficiency; and
  - Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - Send your request to:

    IDR Program Manager
    Department of Social and Health Services
    Aging and Long-Term Support Administration
    Residential Care Services
    PO Box 45600
    Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (360) 725-3218.

Sincerely,

Nicole Vreeland, Field Manager
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
4500 10th Ave SE, Lacey, WA 98504

You are required to be in compliance at all times with all laws and regulations to maintain your certification.

This document references the following complaint numbers: 3621258 , 3658088

The department has completed data collection for the unannounced on-site complaint investigation on 3/13/2019 and 7/18/2019 of:

Aacres WA LLC (Spokane County) #3
5709 W Sunset Hwy Suite 100
Spokane, WA 99224

The following sample was selected for review during the unannounced on-site visit: 4 of 5 current clients and 1 former clients.

The department staff that investigated the agency:

Paula Sanz, BSN, Complaint Investigator
Jessica Sams, MSW, LTC Surveyor
Disa Vradenburg, LTC Surveyor
Nicole Vreeland, Field Manager

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

As a result of the on-site visit(s) the department found that you are not in compliance with the laws and regulations as stated in the cited deficiencies in the enclosed report.

_____ _____

Residential Care Services Date

I understand that to maintain certification, I must be in compliance with all the laws and regulations at all times.

_____ _____

Administrator (or Representative) Date

WAC 388-101-3150 State and federal access to program. The service provider must:
(1) Allow any state or federal department or agency to conduct audits, evaluations, or complaint investigations related to this program or to clients served in this program;
(4) Cooperate with department representatives in the performance of official duties; and

This requirement was not met as evidenced by:
Based on interview and record review, the provider failed to provide all relevant information to department investigators during a complaint investigation related to one client's (Client #1) death. This failure resulted in pertinent information related to alleged neglect of a vulnerable adult being withheld and not voluntarily provided to department investigators, interfering with the department's ability to perform regulatory duties as required by law, and placed all clients at risk of harm.

Review of department records found on 1D 2019, the department received provider notification that Client #1 died unexpectedly while at a gastroenterologist's office preparing for a colonoscopy. The provider report did not include any information regarding possible ingestion of a toxic substance or any allegation of neglect.

Further review of department records found on 3/1/2019, Residential Care Services (RCS) received another report related to Client #1's death with information cleaning vinegar may have been consumed instead of a bowel preparation medication.

On 3/13/2019, RCS Investigator A initiated a complaint investigation and contacted Staff B inquiring about the circumstances surrounding Client #1's death and the allegation Client #1 ingested vinegar. Staff B reported the Quality Improvement (QI) team was conducting the investigation and had all of the records. Staff B reported staff used vinegar in Client #1's home for cleaning purposes, but provided no further information. (As noted in this report in the citation for WAC 388-101-4150, Staff B had knowledge implicating Staff G but did not disclose the information to the RCS Investigators.)

On 4/5/2019, Staff A provided the provider's initial internal investigation via email to RCS Investigator A. Staff A did not inform RCS Investigator A of the availability or provide any of the interviews the provider conducted with the seven staff (Staff D, Staff E, Staff F, Staff G, Staff I, Staff J, and Staff M) identified on the investigation report who had direct knowledge of the events related to Client #1's death on 1D /2019.

When interviewed on 4/9/2019, Staff A reported the internal investigation was inconclusive whether Client #1 drank vinegar and no autopsy report was available yet. Staff A also stated staff denied giving Client #1 the cleaning vinegar instead of the colonoscopy preparation solution, each bottle was clearly labeled, staff knew what vinegar smelled like and the colonoscopy solution was in the refrigerator while the vinegar was next to the refrigerator in a spray bottle.

On 5/20/2019 Staff B sent an updated internal investigation report to RCS Investigator A. The report contained three additions; two notes regarding personnel actions taken with Staff F and Staff G, and one sentence related to use and storage of vinegar, but otherwise remained the same.

On 5/22/2019, RCS Investigator A received a copy of the autopsy report from the county's Medical Examiner (ME). Review of the ME's report dated 5/14/2019 found the ME ruled Client #1's as "death is attributed to superficial necrosis (irreversible death of tissue) and inflammation (tissue becomes reddened, swollen and hot as a reaction to injury or infection) of the esophagus, stomach, and small bowel due to accidental ingestion of household vinegar in place of bowel preparation solution."

After the autopsy results was received, RCS Investigator A conducted additional staff interviews and record reviews from 5/23/2019 through 7/11/2019.

RCS Investigator B and the RCS Field Manager (FM) conducted staff interviews from 7/16/2019 through 7/18/2019. During these interviews, information emerged the provider had written statements and pictures regarding the events surrounding Client #1's death. None of this information was disclosed or provided to the department prior to 7/16/2019.

On 7/16/2019, Staff H reported there were pictures of the empty jug of vinegar. Staff H also reported Staff B instructed them to make a general report to the department's Complaint Resolution Unit (CRU, the department's centralized intake unit that processes all reports and complaints reported to RCS) without mentioning the cleaning vinegar.

When interviewed on 7/16/2019, Staff J reported on the morning of 1D 2019, they took pictures of the remaining half gallon of colonoscopy prep solution in the refrigerator and the directions for the colonoscopy prep they wrote on the white board in Client #1's home. Staff J reported Staff K and Staff M had copies of the pictures.

On 7/16/2019, Staff C provided the pictures and written statements by staff as part of the provider's internal investigation which were not provided to the department prior to this date. Written statements were dated 1D 2019 through 3/1/2019; however, statements by Staff D, Staff G, and Staff O were not dated.

Interview with Staff L on 7/18/2019 was conducted regarding their role in the investigation of the circumstances surrounding Client #1's death. Staff L also provided information reported to them by Staff H and Staff O on 1D 2019, which was not included in the provider's investigative documents and form. During the interview, Staff L stated they kept the bottle of vinegar taken out of Client #1's home in their office. Up until that point, all interviewed staff reported they did not know what happened to the vinegar bottle. After the phone interview, RCS FM and RCS Investigator B went to Staff L's office and observed the same vinegar jug found at Client #1's home by provider staff.

Reference findings cited in WAC 388-101D-0125 and WAC 388-101-4150 for additional details related to this incident.

Plan of Correction: Date Completed:

WAC 388-101-4150 Mandated reporting to the department. Service providers, administrators, owners, and staff:
(1) Are mandated reporters and must meet the requirements of chapter 74.34 RCW;
(2) Must make mandated reports to the department's centralized toll free complaint telephone

number or fax number immediately when:
(a) There is reasonable cause to believe that a vulnerable adult, as defined in chapter 74.34 RCW, has been abandoned, abused, neglected, or financially exploited; or
(4) Must protect the alleged victim and others from further abuse, neglect, abandonment, and financial exploitation; and

This requirement was not met as evidenced by:
Based on interview and record review, the provider failed to ensure eighteen staff (Staff A, Staff B, Staff C, Staff D, Staff E, Staff F, Staff G, Staff H, Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, Staff O, Staff Q, Staff R, and Staff S) with knowledge of alleged neglect of a client (Client #1) understood and implemented mandated reporting requirements and made reports to the department's centralized toll free complaint telephone number or fax (Complaint Resolution Unit/CRU) immediately. This failure precluded the department from having immediate knowledge of alleged neglect of a vulnerable adult and delayed the department's investigation of an allegation of neglect of Client #1, and placed all clients at risk of continued harm.

Review of Client #1's Person Centered Service Plan (PCSP) dated 5/30/18 revealed diagnoses including but not limited to [redacted] The PCSP noted Client #1 needed partial physical assistance to take medications including documenting medications taken, opening medication containers, and reporting adverse reactions. The PCSP documented Client #1 needed a support person in the room with the client or within earshot during awake hours, used a wheelchair for mobility at all times and needed assistance with activities of daily living.

Review of Client #1's medical record showed an appointment on 1/8/2019 with a gastroenterologist. The physician ordered a colonoscopy procedure on [redacted] 2019 with a preparation beginning the night before the procedure involving taking oral medications and drinking one gallon of Polyethylene Glycol Electrolyte (PEG) Solution, half the evening before, and the second half at 3:30am on the day of the procedure. Oral medications ordinarily scheduled for 8:00am were to be taken at 5:00am.

Review of Client #1's "Routine Medication Record" (also known as Medication Administration Record/MAR) for February 2019 found the orders for the prep medications (Dulcolax tablets, Polyethylene Glycol Electrolyte (PEG) Solution, or gas tablets) were not on the MAR nor documented anywhere in the record as given.

Medical records from both the gastroenterologist's office and hospital emergency department (ED) dated 2/27/19 revealed Client #1 was "referred for colonoscopy for evaluation of rectal bleeding and EGD (esophagogastroduodenoscopy) for evaluation of [redacted] and new onset of [redacted] Progress notes by the Registered Nurse (RN) attending the scheduled colonoscopy stated Client #1 arrived at 8:08am on [redacted] 19 accompanied by two staff. The staff brought a half-gallon of the remaining prep solution not ingested by the client. The doctor ordered a different type of solution followed by two glasses of water in order to continue with the procedure. According to the notes, at approximately 9:15am the two staff reported to the RN, "[Client #1] may have ingested 1/2 gallon of Cleaning vinegar instead of the second half of [their] prep." At 9:20am the provider staff notified the RN that Client #1 was short of breath and wheezing. The anesthesiologist listened to Client #1's lungs and ordered a transfer to the emergency room. ED notes stated Client #1 arrived to the ED unresponsive and cyanotic

(turning blue). Resuscitation attempts were not successful and Client #1 was pronounced dead at 10:11am.

Review of the Medical Examiner (ME)'s report dated 5/14/2019 found the ME ruled Client #1's "death is attributed to superficial necrosis (irreversible death of tissue) and inflammation (tissue becomes reddened, swollen and hot as a reaction to injury or infection) of the esophagus, stomach, and small bowel due to accidental ingestion of household vinegar in place of bowel preparation solution."

When interviewed on 3/14/2019, Staff B told Investigator A the provider's Quality Improvement staff was conducting an internal investigation of the circumstances surrounding Client #1's death. Upon request by the Residential Care Services (RCS) Field Manager on 7/16/2019, Staff C provided written statements collected during the provider's investigation. Direct care staff, managers, and administrative staff wrote the statements. Included in the documents was an email from Staff K to administrative staff Staff B, Staff C, Staff H, Staff L, Staff N, and Staff O dated 2/28/2019 directing them to write statements on the chain of events that occurred on 1D 2019 before, during and after (Client #1's) passing. The email stated, "We need to know what you were told, when you were told, how you were told and who told you any information".

Review of the written statements provided by Staff C on 7/16/19 found:

-Staff J wrote a statement dated 3/1/2019 with an account of events from 2/25/2019 through 1D 2019. In their statement, Staff J stated they arrived at Client #1's home on 1D 2019 at 6:00am. They checked the refrigerator and noted the prep solution still in the refrigerator. They checked the medication box and noted no medications were given at 5:00am as previously directed. Staff J called the on call staff, then the doctor's office to report the prep solution was not ingested. Staff I told Staff J the vinegar jug was empty. Staff J documented they just opened it the day before and used some to clean a coffee pot. Staff J went to the procedure with Client #1 and Staff E. Staff J documented when Client #1 started wheezing, coughing and slurring words they "decided to let the nurse know that it might be a possibility but not sure if cleaning vinegar was given instead of solution." In a second statement written on 7/17/2019, Staff J reported they observed Staff I take the empty vinegar bottle to Client #1 and ask if it smelled like what they drank. Staff J reported Client #1 said yes. Staff J did not make a mandatory report with the alleged neglect to the CRU.

-Staff I wrote a statement dated 3/1/2019 with a timeline from 2/25/2019 through 1D 2019. Staff I was assisting Client #1 when Staff J discovered the PEG solution had not been administered. Staff I also noted the morning medications for Client #1 had not been given. Staff I called Staff G who stated they did give the solution. Staff I checked for the container in the recycle bin and found an empty bottle of cleaning vinegar. Staff I called Staff G again and documented Staff G said they gave Client #1 "something". Staff I documented they filled out an incident report and was told to hold off on calling RCS until told. Staff I texted a picture of the vinegar bottle to Staff M. Staff I also documented Staff G called them and Staff I asked Staff G about the vinegar. In a second statement written on 7/18/2019, Staff I wrote they had forgotten that they took the vinegar bottle to Client #1 on the morning of 1D /2019 and had Client #1 smell it. Staff I asked Client #1 if it smelled like what they drank and Client #1 confirmed that it did. Staff I did not make a mandatory report of the alleged neglect to the CRU.

-Staff M wrote a statement dated 2/28/2019 stating they received a call from the on call that Client #1 did not receive all of the prep solution. At 7:00am Staff I and Staff J contacted Staff M and reported the cleaning vinegar was gone. Staff I mentioned the possibility Client #1 was given the vinegar.

-Staff I and Staff J also noted the morning medications were not given. Staff M documented in their statement that the doctor at the procedure knew about the "fear of the vinegar". Staff M did not make a mandatory report of the alleged neglect to CRU.

-Staff E wrote a statement with a timeline from 2/26/2019 through the morning of 1D /2019 without any information regarding vinegar. In an interview with Investigator A on 6/3/2019, Staff E reported they believed Client #1 received vinegar instead of the prep solution and the morning medications were not given. Staff E told Investigator A they went with Client #1 to the procedure and told the emergency room staff of their concern that Client #1 may have ingested vinegar on 1D 2019. Staff E did not make a mandatory report with the alleged neglect to CRU.

-On 1D 2019, Staff G wrote they assisted Client #1 to the bathroom at 3:30am and took the rest of the gallon in the fridge to give to Client #1 while they were in the bathroom. Staff G did not include any information about vinegar in their statement; however, they were aware of the concern as noted in Staff D's, Staff I's and Staff O's statements. Staff G did not make a mandatory report with the alleged neglect to CRU.

-In an undated statement, Staff F wrote they observed Staff G give Client #1 a liquid to drink while in the bathroom with Client #1. They did not mention vinegar in their written statement, however they were aware of the concern as noted in Staff O's statement. Staff F did not make a mandatory report with the alleged neglect to CRU.

-Staff D wrote an undated statement regarding their involvement with directing staff about how to administer the colonoscopy prep and the timing of medications. When Staff D went over the prep instructions with Staff G who was going to be present for the evening and night shifts, Staff D noted when they opened the refrigerator to view the solution, Staff G pointed to the prepared jello and asked if that was the prep. Staff D showed Staff G the correct container and went over the directions to give the oral medications at 5:00am. On the morning of 1D 2019 Staff D went to Client #1's home upon notification of Client #1's death. Staff I told Staff D they were suspicious that the night shift might have given Client #1 vinegar instead of the final prep. Staff D also noted Staff G asked them why vinegar was kept in the refrigerator and reported they opened the refrigerator and "just grabbed the container" from where (they) had put it from the first half of the prep. Staff D did not make a mandatory report of the alleged neglect to CRU.

WAC 388-101-4150 Mandated reporting to the department. Service providers, administrators, owners, and staff:
(1) Are mandated reporters and must meet the requirements of chapter 74.34 RCW;
(2) Must make mandated reports to the department's centralized toll free complaint telephone number or fax number immediately when:
(a) There is reasonable cause to believe that a vulnerable adult, as defined in chapter 74.34 RCW, has been abandoned, abused, neglected, or financially exploited; or
(4) Must protect the alleged victim and others from further abuse, neglect, abandonment, and financial exploitation; and

This requirement was not met as evidenced by:
(continued)

-Staff H wrote a report of the events occurring on 1D/2019 between 9:45am and 10:11am. Staff H documented Staff M called them at 9:45am and explained the prep solution bottle was more than half full that morning and Staff G documented they gave all of the solution to Client #1 during the night. Staff H noted Staff I found an empty gallon jug of vinegar in the recycling bin outside the door and the doctor at the procedure was notified Client #1 may have ingested vinegar. Staff H wrote they called Staff C and was directed to go to Client #1's home to look into the "vinegar and prep solution". Staff H took pictures of the vinegar jug and the white board containing instructions for the prep. Staff H documented they met with Staff B at 10:43am and together they spoke to Staff A and Staff M as well as the DDA Resource Manager Administrator. Staff H did not make a mandatory report regarding the alleged neglect to CRU.

-Staff L documented a timeline of events on 1D 2019 and 2/28/2019. At 12:11pm on 1D/2019, Staff L wrote Staff K told them there was an empty bottle of vinegar in the recycling bin where Staff G stated they put the empty bottle of the prep solution. Staff L wrote there was speculation about if the wrong liquid had accidentally been given. On 7/18/2019, during a phone interview, Staff L reported the empty bottle of vinegar found at Client #1's home by staff was in their office. This was not included in Staff L's written statement. Staff L did not make a mandatory report of the alleged neglect to CRU.

-Staff B wrote a statement dated 3/1/2019 stating Staff C made them aware of Client #1's death. Staff B did not include any information about Client #1's possible ingestion of vinegar, however was aware of the concern as noted in statements by Staff H, Staff L, Staff N, and Staff O in this report. When interviewed by the RCS FM and Investigator B on 7/17/2019 Staff B stated they were involved in the provider's internal investigation. During the process, they did not follow up with updated information regarding neglect by making a report to CRU. They give updated incident reports to DDA and RCS (Investigator). Staff B did not make a mandatory report with the alleged neglect to CRU.

-Staff C wrote a statement on 2/28/2019 with a brief outline of the circumstances related to Client #1's death. There was no information regarding the possible ingestion of vinegar, however Staff C had knowledge of the concern as noted in a statement by Staff H in this report. When interviewed by the RCS FM and Investigator B on 7/17/2019, Staff C reported they knew there was suspicion Client #1 drank vinegar given by staff because Staff H called them "pretty much first thing" on 1D 2019. Staff C reported they told Staff H to go to Client #1's home and look into the situation. Staff C did not make a mandatory report of the alleged neglect to CRU.

-Staff N wrote a document titled, "Re: Investigation Statements" on 2/28/2019. In the document, Staff N wrote they talked to Staff H at 10:28am on 1D 2019 and Staff H told them Client #1 might have been given the vinegar instead of her medication. Staff N then notified Staff B of the information they received from Staff H. Staff N was asked to go to Client #1's home and talk to the staff. Staff N did not make a mandatory report regarding the alleged neglect to CRU.

-Staff O documented in an undated report they were notified of Client #1's death and asked to

conduct a review. Staff O did not document anything about the suspicion of vinegar ingestion, however according to Staff L's written statement, they told Staff O what Staff K told them. Staff O also documented Staff G told them Staff G did not read the label on the bottle of liquid and could not say for sure if it was the prep solution, Staff G admitted they did not read the directions written on the white board and did not give the morning medications because they were not told to. Staff O did not make a mandatory report of the alleged neglect to CRU.

When interviewed on 7/17/2019, Staff Q reported they were involved in the provider's internal investigation by conducting second interviews with Staff F and Staff G on 3/26/2019 and 3/27/2019 respectively and a recent second interview with Staff I on 7/15/2019. Staff Q also stated they had been involved in other internal investigations. When asked what they do when new information comes to their attention that could be considered neglect, Staff Q stated they could not say because they had never been given directions. Staff Q also stated mandated reporting had not been identified as something they needed to do and they had not completed mandatory reporting training but they had read the policy. Staff Q did not make a mandatory report to CRU regarding the allegation of neglect.

Interview with Staff K on 7/22/2019 found they were asked to conduct the first round of interviews as part of the provider's internal investigation involving Client #1's death and this was their first investigation of a "sentinel event". Staff K stated they conducted initial interviews of involved staff however, in March 2019 shortly after the internal investigation was initiated, Staff K went on leave. Staff K stated all members of the provider's QI/QA team were trained on mandated reporting and neglect was to be reported to RCS, APS, and Crime Check then an incident report is sent to DDA. Staff K confirmed they themselves did not make a report of neglect by provider staff to CRU as they "did not believe this was intentional because [Staff G] did not follow policy towards [Client #1]".

Interview with Staff R on 7/17/2019 found they interviewed both Staff F and Staff G while assisting with the provider's internal investigation. Staff R stated they read the staff statements, incident reports and other documents as part of the investigation. Staff G confirmed with Staff R they did not follow the provider's medication administration procedures, including checking the label on the container prior to giving the liquid to Client #1. Staff R stated they did not think Staff G did anything intentionally and it was not clear if there was neglect involved, however they felt not checking the label was neglectful. Staff R stated if the provider was working with one of the RCS investigators they would typically report any new information to the investigator, but not necessarily to CRU. Staff R did not make a mandatory report to CRU regarding the allegation of neglect.

When interviewed by phone on 7/17/2019, Staff S (Administrator and CEO) reported they were informed of Client #1's death on 1D /2019 or the day after. At that time, they did not know about the possibility of ingestion of vinegar. Staff S stated, "sometime in March", Staff K, Staff B, or Staff C told them vinegar may have been consumed by Client #1 in addition to the prep solution. Staff S also stated they read the two investigation reports with contradictory statements and it was not clear whether vinegar was consumed until Staff L told them and gave the autopsy results. Staff S did not make a mandatory report to CRU regarding the allegation of neglect.

During interview on 7/17/2019, Staff A (Executive Director for Oregon and Washington) was

asked if it was part of the provider's policy and procedure to call CRU when neglect was identified; Staff A stated the provider collaborated with RCS and provided the information to the RCS Investigator. The practice had been sharing information with RCS to the investigator during a complaint investigation. When asked if neglect would be reported to CRU and if staff knew to report, Staff A responded they did not know if the practice of sharing information with RCS investigators meant that staff thought they were fulfilling their mandatory reporting responsibility. Staff A did not make a mandatory report to CRU regarding the allegation of neglect.

Review on 7/10/2019 of the provider's policy titled, "Abuse/Neglect & Mandatory Reporting" in part, required all staff to report all incidents of abuse, neglect, and exploitation immediately (within 24hrs) to RCS/CRU (Residential Care Services/Complaint Resolution Unit) and the Program Supervisor or On-Call Emergency Supervisor.

This is a repeat deficiency previously cited on 5/29/2019.

Plan of Correction: Date Completed:

WAC 388-101D-0060 Policies and procedures.
(2) The service provider must develop, implement, and train staff on policies and procedures in all aspects of the medication support they provide, including but not limited to:
(a) Supervision;
(c) Services related to medications and treatments provided under the delegation of a registered nurse consistent with chapter 246-840 WAC;
(e) Medication assistance for clients needing this support; and

This requirement was not met as evidenced by:
Based on interview and record review, the provider failed to develop clear policies and procedures for supporting clients with medications consistent with regulatory requirements and defining the difference between assistance and administration of medications. This failure resulted in conflicting directions regarding medication assistance versus medication administration, and placed all clients at risk of harm.

According to WAC (Washington Administrative Code) 388-101-3000 Definitions:

"Medication administration" means the direct application of a prescribed medication whether by injection, inhalation, ingestion, or other means, to the body of the client by an individual legally authorized to do so.

"Medication assistance" means assistance with self-administration of medication rendered by a non-practitioner to a client receiving certified community residential services and supports in accordance with chapter 69.41 RCW (Revised Code of Washington) and chapter 246-888 WAC.

Review of the provider's policy titled, "Assistance with Medication" with an effective date of 10/15/2016, found the terms "assistance" and "administration" used interchangeably, particularly in the section titled "Six Rights of Medication Administration" also known as "The Five Rights Plus".

The following statements were found in a paragraph defining the process to incorporate the client's six rights: "The following is the six-step process to provide assistance with medication administration" and "The six steps of providing assistance with medication administration are as follows:"

In the section for Step 1: "Evaluate the Person Supported" the policy stated, "The first step is to evaluate the person supported prior to them taking the medication. A person must be in a stable medical condition for us to assist with their medications". Evaluation of a client's stable condition is a nurse delegator task to determine if staff can administer a medication through the nurse delegation process and not within the scope of non-professional staff.

In the section for "Step 5: Document" the policy stated to "document the medication administration on the MAR" and "document each time a medication is taken immediately after providing assistance".

In the section for "Step 6: Observe for Side Effects and Medication Interactions" the policy stated, "the final step of the medication administration process is to observe the person supported after assisting with the medication".

Reference findings cited in WAC 388-101D-0295 and WAC 388-101D-0315 for additional details related to this incident.

Plan of Correction: Date Completed:

WAC 388-101D-0125 Client rights. Clients have the same legal rights and responsibilities guaranteed to all other individuals by the United States Constitution, federal and state law unless limited through legal processes. Service providers must promote and protect all of the following client rights, including but not limited to:
(5) The right to be free from harm, including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, abandonment, and financial exploitation; and

This requirement was not met as evidenced by:
Based on interview and record review, the provider failed to ensure one client (Client #1) received medication as prescribed, received required assistance from staff with preparation for a scheduled medical procedure, and received immediate medical attention after staff identified concern of household cleaner ingestion. This failure resulted in Client #1 ingesting household cleaning vinegar instead of the physician's ordered medication and the client not being able to obtain medical evaluation upon initial concern of the client potentially ingesting household cleaner which culminated in the client's death, and placed all clients at continued risk of harm.

Review of Client #1's Person Centered Service Plan (PCSP) dated 5/30/2018 revealed diagnoses including but not limited to [redacted]1D[redacted] The PCSP noted Client #1 needed partial physical assistance to take medications, including documenting medications taken, opening medication containers, and reporting adverse reactions. The PCSP documented Client #1 needed assistance with avoiding health and safety hazards, obtaining healthcare services, and advocating for self.

Review of a provider Incident Report (IR) submitted by the provider to Developmental Disabilities Administration (DDA) and Residential Care Services (RCS) on 1D /2019 stated the following:

"[Client #1] went to get a colonoscopy this morning at [local healthcare provider] at 7:30am. [Client #1] had not finished the colon prep solution prior to the appointment so the doctor said [they] can finish it at the appointment and they would push the colonoscopy back approximately (sic) 4 hours. While at the appointment, [Client #1] began having trouble breathing and was slurring [their words]. [Client #1] was taken to the Emergency Room (ER) at [local healthcare provider] where they noticed [Client #1's] pulse was faint and began attempting to resuscitate [them]. The ER (Emergency Room) doctor found [their] POLST (Physician Orders for Life-Sustaining Treatment) from 2015, which indicated not to resuscitate. They stopped all forms of resuscitation and [Client #1] passed away shortly after. [Their] estimated time of death was 10:11am. An RCS report was completed for Unexpected Client Death".

Review of Client #1's medical record from their gastroenterology appointment on 1/8/2019 revealed Client #1 was to prepare for a colonoscopy on 1D 2019 by taking two Dulcolax tablets (stool softener) at 5:00pm the evening before the procedure and begin drinking Polyethylene
Glycol Electrolyte (PEG) Solution until half of the solution was ingested (one half gallon). Prescribed gas tablets were to be taken at 9:00pm and again at 10:00pm (the evening before the colonoscopy). At 3:30am on the day of the procedure, Client #1 was to drink the remaining PEG solution (the other half gallon).

Review of pharmacy records revealed Staff E picked up Client #1's colonoscopy preparation medications on 2/25/2019 at 3:40pm. Further review found Client #1's Routine Medication Record (also known as MAR) for February 2019 revealed no written documentation of Dulcolax tablets, Polyethylene Glycol Electrolyte (PEG) solution, or gas tablets being prescribed or administered to Client #1.

Review of Client #1's medical records dated 1D /2019 from a gastroenterologist revealed Client #1 was scheduled for colonoscopy and arrived at 8:08am accompanied by two staff. The staff brought a half-gallon of the PEG solution not ingested by the client. The doctor ordered a different type of solution followed by two glasses of water in order to continue with the scheduled procedure. According to the notes, at approximately 9:15am, the two staff reported to the Registered Nurse (RN), "[Client #1] may have ingested 1/2 gallon of Cleaning vinegar instead of the second half of [their] prep (the PEG solution)." At 9:20am, the provider staff notified the RN that Client #1 was short of breath and wheezing. The anesthesiologist listened to Client #1's lungs and ordered a transfer to the ER. ER notes stated Client #1 arrived to the ER unresponsive and cyanotic (turning blue). Resuscitation attempts were not successful and Client #1 was pronounced dead at 10:11am.

Interview with with Staff E (Direct Support Professional) on 6/3/2019 revealed they had delivered Client #1's colonoscopy preparation medication to the home the day before the 1D /2019 colonoscopy and did not add the medications onto Client #1's MAR. Staff E reported if a medication came into a client's home, they were supposed to write the new medications on the MAR.

Interview on 6/12/2019 with Staff F (Direct Support Professional) revealed they denied administering Client #1 any medication on the day of the client's death. Staff F stated they worked with Staff G from 2:00pm on 2/26/2019 until 6:00am on 2/27/2019. Staff F stated the colonoscopy preparation medications had not been written on the MAR and therefore their co-staff, Staff G, should not have administered any medication without calling the pharmacy to verify the medication should have been given. Staff F stated Staff G had given the colonoscopy preparation medications anyway.

During a follow-up interview on 7/10/2019, Staff F reported Client #1 was with staff on 2/26/2019 from 8:00pm until 10:00pm and stated in the early morning hours of 1D /2019, Staff G had brought liquid in a red cup (Client #1's special cup) while Client #1 was in the bathroom. Staff F was not sure if the bowel preparation medication (PEG solution) was in the cup or if it was another liquid.

During an interview on 7/10/2019, Staff I (Direct Support Professional) stated they worked at Client #1's home from 6:00am until 2:00pm on 1D /2019 and had been notified in the morning of 1D 2019 by their co-staff (Staff J) there was a half jug of PEG solution in Client #1's refrigerator. Staff I stated, per the provider's policy, they contacted Staff G via text message to determine if Client #1 had been assisted with the colonoscopy preparation medications. Staff I reported Staff G had texted back a message they "did give [Client #1] something" and requested Staff I check the recycling bin for the empty container. Staff I reported they checked the recycling bin and found an empty jug of vinegar. Staff I stated the PEG solution was in a squared-off plastic jug while the vinegar jug was rounded, "they looked nothing alike." Staff I reported they had Client #1 smell the jug (the empty vinegar jug) and asked Client #1 if it smelled like what they had been given earlier that morning; Client #1 stated it did. Staff I stated they had not told their supervisor (Program Coordinator), the Program Director (who came later that day to ask questions), or the provider's internal investigators about Client #1 stating what Staff G administered to them with smelled like vinegar. When asked why they did not report the interaction to management staff, Staff I stated, "It was a detail I forgot to mention, there were so many questions that day."

Interview with Staff M on 7/16/2019 found they were informed the morning of 1D 2019 of concerns related to Client #1 potentially ingesting vinegar as staff informed them the client's PEG solution was found still at the client's home by either Staff I or Staff J, and instructed them to tell Client #1's doctor about the possible vinegar ingestion.

Interview with Staff H on 7/16/2019 found they had knowledge of Client #1's possible vinegar ingestion after receiving a call from Staff M and received direction from Staff C to go Client #1's home to check the medication box. Staff I was at the home and said staff put an empty jug in the recycling bin and the only jug found was the vinegar jug. Staff H was responsible for authoring the IR related to Client #1's death on 1D 2019 and stated concern of Client #1 potentially ingesting cleaning vinegar was not mentioned as they were instructed to make a "basic report" by Staff B "since there wasn't enough information" and they are not privy to any additional information due to the provider's internal investigation.

Interview with Staff C on 7/16/2019 found they received a phone call the morning of 1D 2019 from Staff H between 9:00am-10:00am, and was informed Client #1 had complications at their colonoscopy appointment and there could have been possibility of the client drinking cleaning

vinegar since the PEG solution was still in the client's home. Staff C instructed Staff H to go to Client #1's home to look at medications. When asked if there could be a different outcome if the 6:00am staff called 911 after learning the client could have ingested cleaning vinegar, Staff C stated they did not know how much vinegar was consumed.

Interview with Staff B on 7/17/2019 found Staff C contacted and informed them on 1D 2019 of Client #1's colonoscopy not going well; it was reported Staff M called Staff H, Staff H called Staff C. Staff A was contacted due to Client #1's death being a "sentinel event". Staff A stated the provider categorized a client death, physical or sexual assault as a sentinel event. Staff B and Staff H spoke with Staff A over the phone and Staff H was instructed to report to the department as soon as possible. Staff B stated the initial person with knowledge generally should make the report and Staff H was instructed to report as soon as possible. Staff B reported they could not recall the specific timeline of when learning of Client #1 potentially ingesting cleaning vinegar.

Follow-up interview with Staff A on 7/17/2019 found they were contacted by Staff B on 1D 2019 at 10:46am after Client #1 passed away and the client's colonoscopy prep (PEG solution) was not empty. Staff A stated they were not informed of Client #1 potentially consuming cleaning vinegar during the initial phone call. Staff A reported the Administrator was contacted to discuss who would lead the internal investigation.

Interview with Staff S (Administrator and CEO) on 7/17/2019 found they were contacted within 24 hours of Client #1's death and an investigation was initiated. Staff S reported the initial investigation concluded on or around 4/4/2019 and did not have initial knowledge of Client #1's possible cleaning vinegar ingestion prior to their death.

Interview with Staff J on 7/16/2019 found they worked with Staff I and Staff E came in to help take Client #1 to their colonoscopy appointment. Staff J came on shift on 1D 2019 at 6:00am and checked to ensure Client #1 took the PEG solution since it was necessary for the client's appointment that morning. Staff J stated she observed the PEG solution still in the client's refrigerator and called on-call management for direction; the on-call manager (unnamed) reportedly instructed them to call the doctor or hospital. Staff J further reported Staff I went outside to salt the walkways of the home and found a distilled vinegar jug. Staff J stated they purchased the vinegar the day prior (2/26/2019) at 2:00pm and told Staff G the vinegar was bought to clean the coffee pot and later put it in the corner on the kitchen counter. Staff J stated Staff I contacted Staff G about administering the PEG solution to Client #1, and Staff G reportedly stated they did; Staff I then asked Client #1 if the vinegar is what they drank and the client said "yes". Staff J stated upon checking in for Client #1's appointment, Client #1's speech "was weird" and notified the RN there was concern of the client possibly drinking vinegar solution due to the client's fluid restriction. Staff J reported they wrote instructions about the client's colonoscopy preparation on the white board at the client's home and took pictures and sent them to Staff K along with pictures of the PEG solution bottle.

Review of the provider's investigative notes and pictures, provided to RCS Field Manager and RCS Investigator B on 7/16/2019 (following a request to the provider for this information), found the following staff interviews as part of the provider's internal investigation of Client #1's death:

• Staff I, handwritten, signed and dated 3/1/2019, not all inclusive:
-On 1D/2019 at 6:00am while they arrived on shift, Staff J "discovered the PEG solution had not been administered I called [Staff G] and asked why the PEG solution was not given. [Staff G] assured me that the PEG solution was given. That they emptied it. When clearly it was not given. I hung up with [Staff G] and checked the recycle bin. On top of the recycle bin was an empty gallon bottle of cleaning vinegar. I called [Staff G] and asked [them] again why wasn't the solution administered. [Staff G] then assures me that they gave her "something".
-"8:00ish I filled out an IR and was told to hold off on contacting RCS until told. I had texted a picture of the vinegar bottle to [Staff M] and let her know of the odd situation. [Staff G] called me and I asked her about the vinegar. [Staff J] told me the vinegar bottle was half empty the day before when [they] left."

WAC 388-101D-0125 Client rights. Clients have the same legal rights and responsibilities guaranteed to all other individuals by the United States Constitution, federal and state law unless limited through legal processes. Service providers must promote and protect all of the following client rights, including but not limited to:
(5) The right to be free from harm, including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, abandonment, and financial exploitation; and

This requirement was not met as evidenced by:
(continued)

-"9:00ish" Staff I was asked to find Client #1's POLST and they could not find it. "Shortly after the conversation with [Staff J]", Staff H came to the house and "started asking questions. [Staff H asked to see the vinegar bottle and I told [them] I cut it to use as an ice melt spreader. [Staff H] then told that [Client #1] might not make it and to not talk to anyone about it."

• Staff J, handwritten, dated 3/1 (no year documented), not all inclusive:
1D, they came on shift at 6am, checked the refrigerator and noticed half of (Client #1's) solution was in the fridge, checked the medication box and noticed Client #1 was not given medications at 5am, and called oncall, then the medical provider "to see if still can do procedure. Nurse was supposed to call back. [Staff I] said something about using the vinegar jug for de-icer and I said what you mean that jug of vinegar is gone I just opened it yesterday to clean the coffee pot and I had it in the corner by the coffee pot." The note further stated they decided to go to the (colonoscopy) appointment and the doctor said the prep could be finished there. "As time went by, [Client #1] started wheezing and coughing and then slurring words so I decided to let nurse know that might be a possibility but not sure if cleaning vinegar was given instead of solution."

• Staff D (House Manager), handwritten, undated, not all inclusive:
-Staff D was notified by staff that Client #1 did not finish their prep as half the bottle was still full, staff contacted the hospital and was awaiting a return call, she (no specific staff identified) later asked if she could cancel or take Client #1 to their appointment, and Staff D stated she directed staff to take Client #1 and the hospital will probably finish.
-Staff D was notified by Staff J Client #1 had died. "When I arrived at the house, [Staff I] told me that they were suspicious that the grave shift might have given her vinegar instead of the final prep. She said that [Staff G] told her that [Client #1] finished it and put the bottle in the recycling bin, [Staff I] only found an empty vinegar bottle".

-[Staff G] asked me why vinegar was kept in the fridge. I told [them] that the fridge did not have vinegar in it when I opened it. [They] told me that [they] opened the fridge and just grabbed the container from where [Staff G] had put it from the first half of the prep."

• Staff M (Program Coordinator), handwritten, dated 2/28/2019, not all inclusive:
-On the date of Client #1's colonoscopy appointment 1D 2019), Staff M received a call from an oncall provider staff notified them of Client #1 did not finish the prep (PEG) solution.
-Staff (unnamed) contacted Staff M at 7am explaining the solution was not given in full, made the choice to take Client #1 to the appointment anyway, and "they expressed that it was weird that the cleaning vinegar was gone and outside in the recycling bin."

• Staff H (Program Director), typed with their signature, undated, not all inclusive:
1D 2019 at 9:45am, Staff M called them as Client #1 was reportedly lethargic, having trouble breathing, wheezing, and slurring their words and was sent to the ED, the client's prep solution jug was still more than half full when the morning staff arrived to Client #1's home, Staff G entered in the activity log all of the prep solution was administered to the client, but Staff I found an empty gallon jug of vinegar in the recycling outside the door. Staff H was directed by Staff C "and look into the vinegar and prep solution and meds and documentation."
-Staff H spoke to Staff M and recounted the timeline of events, based on Staff M's conversations with staff; a copy of the information put into the IR and later sent to the department (RCS and DDA).
-Staff O (provider's Registered Nurse Delegator) came to Staff H's office and reviewed Client #1's records, interviewed Staff G, and both Staff O and Staff G discussed whether or not Staff G would be returning back to work; "I said it depends on what [they] said. [Staff O and I discussed the information regarding the vinegar."
-Staff F was interviewed, Staff O, Staff B (Eastern Regional Director) discussed the interviews with Staff G and Staff F.

• Staff C (Area Director for Eastern Washington), email dated 1D 2019 at 4:39pm to Staff K, not all inclusive:
-Staff H called them at 9:47am to inform them of Client #1's death while at an appointment for their colonoscopy and the department was notified of "unexpected death".

• Staff B, email dated 3/1/2019 to Staff K, not all inclusive:
-Staff C contacted them at 10:01am on 1D /2019 and reported Client #1 was at their colonoscopy appointment, became unstable, and was sent to the ED.
-Staff C called back at 10:12am notifying them of Client #1's death.
-Staff A was contacted at 10:42am informing them of the incident; Staff A called back at 11:07am letting Staff B know they had an emergency meeting with the Executive Team and identified Staff O would be completing a medical review and taking the lead on the investigation.

• Staff O, typed, undated, not all inclusive:
-Staff L (Senior director of Residential Quality and Health Services, Registered Nurse) called them at 11:30am on 1D /2019 of Client #1's death and asked for a chart review.
-Staff H spoke with them around 2:30pm on 1D /2019 with Staff M present in the office, and reviewed Client #1's medical history.
-Staff O conducted an interview with Staff G at 3:10pm on 1D /2019 and discussed Staff G's

admission of administering Client #1 medications but did not check the label on the jug of liquid she administered to client as the PEG solution. It was stated Staff G had given medications without them being on the MAR, and there were concerns about sending Staff G back to their shift they were currently scheduled for.
-Staff O stated "[Staff H] seemed conflicted and proceeded to tell me that an empty Vinegar jug had been found in the recyle. Since the Golytely (PEG solution) was found, half full, and [Staff G] said [Client #1] had finished it, staff had gone to the recycle bin to look for the empty jug."
-Staff B was in Staff H's office after Staff O interviewed Staff F at 4:30pm on 1D/2019; Staff B asked what Staff O thought and it was decided Staff O would return to Client #1's house to suspend Staff G "to insure client safety".
-While en route to Client #1's home to suspend Staff G, Staff L called and Staff O "reported what I know at that point".
-When at Client #1's home, Staff O observed a recycle trash can without a lid and an empty jug labeled "cleaning vinegar" on the top; Staff O later observed a white board on the wall and asked Staff G if they read the white board (picture provided by the provider with these notes contained a white board with instructions for Client #1's colonoscopy prep) and Staff G said they did not read it and they usually did but for some reason, did not read the white board the day prior 1D/2019). Staff G also reported to Staff O she did not give Client #1 their 5:00am medications that morning because it was not explained to them by Staff D (House Manager).

• Staff L, typed note, not signed or dated, not all inclusive:
-They were notified at 11:09am on 1D/2019 of Client #1's death and was unaware of the circumstances.
-At 12:11pm, Staff K called to inform Staff L of Client #1's passing and was informed of Client #1 having a colonoscopy scheduled, the client went to the appointment, and was transported to the hospital and due to a DNR (Do Not Resuscitate), no other measures were taken to revive Client #1. "[Staff K] informed me that the morning staff reportedly noticed that there was still half of the GoLYTELY (PEG solution) colonoscopy prep liquid still in the refrigerator [Staff K] also reported that it may or may not be relevant but there was an empty bottle of vinegar in the recycling bin where the staff who gave the eds during the night stated [they] had put the empty bottle of GoLYTELY. Since the bottle of the GoLYTELY was not, in fact empty, there was speculation about if the wrong liquid had accidentally been given."
-At 6:15pm, Staff O was contacted for an update and Staff O (who was with Staff H) was on their way to Client #1's home to suspend night staff "and also investigate the question about the bottle of vinegar." Staff O reported the staff who administered the GoLYTELY stated they had grabbed the container from the refrigerator at 3:30am where they had left it after the 5pm administration (first half of the PEG solution). Per Staff O, the remainder of the liquid was given to Client #1 and the empty container was left on the counter where another staff had collected the recycling and taken it out. It was also reported staff failed to read the label on the medication, "just grabbed the jug from the fridge and that staff reported they had not read the directions left on the white board by the lead, and that the meds from the colonoscopy prep were not on the MAR."
-At 6:34pm, Staff A, Staff B, and Staff K were in contact with Staff L and relayed what they had learned.
-At 6:36pm, Staff L sent a text message to Staff O stating, "don't send an email with your findings. Keep notes and we will discuss tomorrow morning with the team."
-On 2/28/2019 at 9:23am, Staff L met with Staff O, Staff K, Staff R, and Staff U to discuss information that Staff O and Staff K had learned thus far.

Included in the provider's investigative notes were pictures of a white board with written instructions for Client #1's colonoscopy preparation, detailed with times of when to administer the client's medications including the PEG solution. Also included were a bottle with a pharmacy label (illegible in the picture due to font size) and a one gallon "Heinz All Natural Cleaning Vinegar, Special Cleaning Strength" on the front of the label and "Ingredients: Vinegar Diluted with Water to a Cleaning Strength of 6% acidity" on one side of the label.

Review of the medical examiner's records indicate on 1D 2019, revealed ER nursing staff stated the decedent (Client #1) expressed clear fluid rectally during the code which smelled like vinegar. On a note dated 2/28/2019, Washington Poison Control Center was contacted and household cleaning vinegar was an irritant, and depending on the concentration, it can result in corrosive injuries to the gastrointestinal tract.

Review of the medical examiner's autopsy report dated 5/14/2019 revealed Client #1 drank PEG Solution from a 4-liter jug the evening before the colonoscopy scheduled on 1D 2019. The jug was found to be still half-full the morning of 1D 2019. A jug of cleaning vinegar had been present in Client #1's home while Client #1 was assisted with drinking the PEG solution as it was discovered empty in the morning. The report further stated Client #1 consumed the vinegar instead of the bowel preparation solution and the medical examiner ruled Client #1's death was attributed to superficial necrosis (death of tissue often caused by radiation and chemicals, and cannot be reversed) and inflammation of the esophagus, stomach, and small bowel due to accidental ingestion of household vinegar in place of bowel preparation solution.

Review of the Mortality Review for Client #1 submitted to DDA by the provider dated 3/6/2019 contained the same information noted in the IR dated 1D /2019. There was no information found in the documents provided to DDA as part of the Mortality Review that indicated vinegar ingestion was suspected and may be a cause of concern prior to Client #1's death.

Review of department records on 7/18/2019 found the provider did not report further information or updates to the original report provided to RCS on 1D /2019 regarding Client #1's death or neglect of provider staff.

This is a repeat deficiency previously cited on 12/28/2018.

Reference findings cited in WAC 388-101D-0295 for additional details related to this incident.

Plan of Correction: Date Completed:

WAC 388-101D-0315 Medication administration Nurse delegation. If a client is assessed as requiring medication administration and the service provider is not a practitioner, the service provider must ensure the assistance is provided by a licensed health care professional or under nurse delegation as per chapters 246-840 18.79 RCW.

This requirement was not met as evidenced by:
Based on interview and record review, the provider failed to ensure a Registered Nurse Delegator (RND, Staff P) employed by the provider understood and followed regulatory requirements of WAC 246-840 when they utilized nurse delegation forms for three clients

(Client #1, Client #4 and Client #5) who did not require nurse delegation for oral medications and used contradictory language on nurse delegation documents for one client (Client #2) delegated for oral and topical medications. This failure resulted in documentation of instructions and actions staff were expected to follow being confusing and unclear, and placed all clients at risk of harm.

WAC 246-840-930 Criteria for Delegation (12) stated the delegating Registered Nurse (RN) requirements included providing specific written instructions for each delegated task with a clear description of the procedure.

Review of Client #1's Person Centered Service Plan (PCSP) dated 5/30/2018, revealed diagnoses including but not limited to [redacted] Client #1's Individual Instruction and Support Plan (IISP) signed 7/6/2018 stated they required partial assistance with taking medications. Client #1's record contained an unsigned "ALTSA (Aging and Long-Term Support Administration) Nurse Delegation Referral and Communication Case/Resource Manager's Request" form with Staff P's name dated 10/30/2018. The form stated Client #1 was authorized for nurse delegation for "Orals" and "Topicals".

Review on 7/16/2019 of Client #1's record found copies of DSHS (Department of Social and Health Services) nurse delegation forms titled, "Nurse Delegation: Instructions for Nursing Task" in Client #1's record. The documents contained Staff P's name and some areas on the forms contained the type of directions to staff normally found in records of clients who were nurse delegated for oral medication administration. An example found in box #5 titled, "Delegated Task and Expected Outcome", the words "General Medications: [Client #1] will receive [their] medications as ordered by [their] physician. In Box #6 where typically the medications, dosages, and frequency were listed was the statement, "See MAR (Medication Administration Record) for list of current medications." Box #8 included directions to staff to call the RND if there were changes in condition, orders, refusals, or errors and that the RND must verify and approve any new of changed orders before they can take place. Other subsequent statements and instructions on the forms used the terminology of administration versus assistance and to call the delegating nurse approximately five more times on the document.

Client #1's record also included a referral for nurse delegation for oral and topical medications dated 10/30/2018 and an assessment completed by Staff P on 11/1/2018 indicating Client #1 required only delegation for topical medications.

Interview with Staff P on 7/16/2019 found when asked why the form stated Client #1 was nurse delegated for oral medications and the form provided directions as if Client #1 was nurse delegated for oral medications, Staff P stated they "always do a general form" and they "did this for everybody"; each person had a general form because Staff P was told that was what they needed to do. Staff P stated Client #1 did not receive nurse delegation services for oral medications and was only delegated for topical medications "as necessary". Staff P stated because Client #1 knew what medications they took and they could ask for any PRN (as needed) medications, they did not require nurse delegation for administration of oral medications, and did not know why there was a referral in the record for oral medications dated 10/31/2018.

Review of Client #2's PCSP dated 12/19/2018, revealed diagnoses including but not limited to [redacted] 1D [redacted] Client #2 required nurse delegation for administration of oral and topical medications as they did not remember to take medications, were unable to follow frequency or dosage, and received a psychotropic drug requiring monitoring.

Review of nurse delegation documents for Client #2 found a "Nurse Delegation: Nursing Visit" document dated 4/23/2019. In Box #5 "Client Requires Nurse Delegation for These Task(s):" Staff P wrote "Oral medications as necessary, Topical ointments as necessary". However, on the forms titled, "Nurse Delegation: Instructions for Nursing Task" provided specific, detailed directions for the tasks.

Client #4's PCSP dated 11/13/2018, revealed diagnoses including but not limited to [redacted] 1D [redacted] Client #4 required nurse delegation for topical medications, eye drops, eardrops, and blood glucose monitoring once daily. Client #4 did not require nurse delegation for oral medications.

Review of Client #5's PCSP dated 2/21/2019, revealed diagnoses including [redacted] 1D [redacted] Client #5 required nurse delegation for eye drops and topical medications. Client #5 did not require nurse delegation for oral medications.

Record review of Client #4 and Client #5's records found DSHS form 13-678 "Nurse Delegation: Instructions for Nursing Task" stating "General Medications" as the delegated task when neither client required delegation for oral medications. The document was written as if nurse delegation for oral medications was required, including language stating "Delegation is specific to (the name of the client)", "notify the RND for any changes in condition, change in orders, medical refusals or errors" and the "delegation is classified as necessary".

When interviewed on 7/17/2019, Staff T stated Client #4 could take all oral medications themselves. Topicals were as needed/appropriate due to have a bad arm, Client #4 could not apply topicals themselves but may need help reaching certain spots. Staff T reported they do not call the RND when oral medications change.

When asked to clarify the use of DSHS nurse delegation forms for clients who did not require delegation of oral medications on 7/16/2019, Staff P stated it was their normal practice to use the DSHS nurse delegation forms for all clients with oral medications, including those who are not nurse delegated for oral medications. Regarding the "as appropriate" or "as necessary" verbiage, Staff P stated this was not used often but there were a few clients with it and Staff P was unsure if it was terminology in the nurse delegation policies.

Staff P further stated they began employment with the provider about a year ago and saw Staff O (another provider RND) document in this manner so they just copied and pasted when updating client records. Staff P went on to say the way it was explained to them when they started working for the provider, the state (State of Washington) wanted them to do all ND; they were "doing whatever (Staff O) has been doing the last several years". One page of Client #1's forms included a different client's first name in the body of the form. When pointed out to Staff P, they

acknowledged they copied and pasted from one client's form into another and said, "Maybe it's not the best thing to put for everyone I can see how that is confusing."

On 7/26/2019, the RCS FM and RCS Investigator B consulted with a department Nurse Delegation Program Manager. When asked if it was appropriate to use DSHS nurse delegation forms for clients who were not nurse delegated for the administration of medications, they stated it would not be appropriate.

On 7/26/2019, the RCS FM and RCS Investigator B consulted with three Washington State Department of Health representatives (Nursing Consultation Advisor, Nursing Consultant for Public Health, and Legal Manager for the Nursing Care Quality Assurance Commission) regarding nurse delegation services in the Supported Living setting. They stated it was not appropriate to have "general" rules for medications or "as necessary" or "as appropriate" language when delegating medications, and the directions should be specific and detailed. They also stated using nurse delegation forms for clients not delegated would not be advisable and could create confusion between assistance and administration of medications.

Plan of Correction: Date Completed:

WAC 388-101D-0295 Medication services General.
(1) If the service provider is involved in assisting any client with medications, as identified in the client's individual support plan, the service provider must:
(a) Have systems in place to ensure that medications are given as ordered and in a manner that safeguards the client's health and safety;
(b) Ensure that each client receives their medication as prescribed, except as provided for in the medication refusal section or in the medication assistance section regarding altering medication; and

This requirement was not met as evidenced by:
Based on interview and record review, the provider failed to provide required medication assistance to one client (Client #1) in a safe manner by four staff (Staff D, Staff E, Staff G and Staff J). This failure resulted in actual harm to Client #1 when four staff (Staff D, E, G and J) failed to document prescribed medications for a colonoscopy procedure on the Medication Administration Record (MAR), provided colonoscopy medications relying on memory and not specific to the client's instructional plan, staff (Staff G) did not provide physician ordered medications as prescribed, non-medical staff (Staff D and Staff E) held medications by taking verbal orders over the phone, and placed all clients at continued risk of harm.

Review of Client #1's Person Centered Service Plan (PCSP) dated 5/30/2018 revealed diagnoses including but not limited to [redacted] 1D [redacted] The PCSP noted Client #1 needed staff assistance to take physician ordered medications including opening containers, documentation, re-ordering medications and reporting adverse reactions. Client #1's Individual Instruction and Support Plan (IISP) signed 7/6/2018 stated they required partial assistance with taking medications.

Review of Client #1's record found documentation of a gastroenterology appointment on 1/8/2019. The physician ordered a colonoscopy procedure for [redacted] 1D 2019 (scheduled at 7:30am)

with preparation beginning the night before. The orders included taking two Dulcolax tablets (stool softener) at 5:00pm the evening before the procedure (2/26/2019), begin drinking a gallon of Polyethylene Glycol Electrolyte (PEG) Solution (laxative) until half of the solution was ingested then store the remaining half gallon in the refrigerator. Orders also stated to take tablets for gas at 9:00pm and again at 10:00pm (the evening before the colonoscopy) followed by eight ounces of clear liquid. At 3:30am on the day of the procedure, Client #1 was to drink the remaining PEG solution (preparation/prep), eight ounces every 10-15 minutes and finish the remaining solution at least two hours before the procedure.

Review of pharmacy records revealed Staff E picked up Client #1's colonoscopy preparation medications on 2/25/2019 at 3:40pm.

Review of Client #1's MAR for February 2019 found no documentation of the Dulcolax tablets, Polyethylene Glycol Electrolyte (PEG) Solution, or gas tablets. Further review found documentation some medications were held (not given) or designated to hold on the day of the procedure as referenced by circles around the signature square for the date/time of the medication. Documentation on the back of the MAR included a statement on 2/20/2019 for Aspirin, "to hold per Dr. (doctor) until after procedure on 1D /2019" initialed as written by Staff J. A second statement dated 1D /2019 and initialed by Staff E stated, "Hold per GI DR (gastroenterologist doctor) All vitamins---------- Hold until after procedure".

According to documentation on the MAR, the medication held was:
--Aspirin 325 mg tablet, one tablet twice daily for blood clot prevention - held from 8:00am on 2/20/2019 through 2/26/2019

Medications scheduled for hold the day of the procedure were:
--Therems - M tablet, one tablet once daily in the morning for supplement- designated to hold on 2/27/2019
--Vitamin B-6 100mg table every morning as a nutritional supplement- designated to hold on 2/27/2019
--Vitamin D3 2,000IU, one soft gel every morning for supplement- designated to hold on 2/27/2019
--Calcium Carb Antac 500mg, one tablet every morning for supplement - designated to hold on 2/27/2019
--Docusate Sod 100mg, one twice daily for constipation - designated to hold on 1D /2019
--Senna-S 8.6 / 50mg tablet, twice daily for constipation- designated to hold on 1D 2019

Review of physician directions for the colonoscopy procedure found physician orders to stop all iron and herbal supplements seven days before the procedure. Another document in Client #1's record was a Facsimile Transmittal Sheet dated 1/10/2019 from Staff E to Staff M and an unknown person. The document contained written appointment instructions, the location of the pharmacy to pick up the preparation supplies, the location of the scheduled procedure, directions to give no Aspirin seven days prior, and a note Staff E spoke to a named person at the physician office. Neither document contained directions to hold all vitamins, the Docusate, or the Senna.

In an email dated 7/17/2019, Staff B reported Staff D took orders over the phone from the doctor regarding what medications to hold and to give medications ordinarily scheduled for 8:00am at 5:00am. Staff B also stated Staff E took verbal instructions on what medications to administer

and hold on the day of the procedure. Neither Staff D nor Staff E were medical professionals with the ability to take doctor orders over the phone.

When interviewed on 7/18/2019 and asked if non-medical professional staff were allowed to take verbal orders from physicians, Staff L (Senior Director of Residential Quality and Health Services and a Registered Nurse/RN) stated they were not. Staff L agreed Staff E should not have taken the verbal orders and should have obtained written orders as Client #1's home had a fax machine where orders should have been sent.

Record review of a provider memo titled "Medication Expectation" written by Staff C (Area Director) on 11/28/2018 and sent to Program Coordinators and On-Call Coordinators with a cc (carbon copy) to Program Directors found the following statement: "Note: it is up to a medical professional to make the decision to write a hold order for the medication".

Staff J wrote a statement dated 3/1/2019 with an account of events regarding Client #1 from 2/25/2019 through 1D/2019. In their statement, Staff J stated they arrived at Client #1's home on 1D/2019 at 6:00am. They checked the refrigerator and noted the remaining colonoscopy preparation solution still in the refrigerator. They checked the medication box and noted no medications were given at 5:00am as previously directed. Staff J called the on-call staff, then the doctor's office and left a message to report Client #1 did not ingest all of the prep solution.

When interviewed on 7/16/2019, Staff J reported they knew the colonoscopy prep medications were not written on Client #1's MAR, but they thought it was sufficient to use the directions provided by the physician. They also stated they wrote all instructions on the white board in Client #1's home, including what time to take the medications and the instructions from the physician.

Staff I wrote a statement dated 3/1/2019 with a timeline from 2/25/2019 through 1D 2019. Staff I was assisting Client #1 in the restroom when Staff J discovered some of the PEG solution had not been administered. Staff I also noted the morning meds for Client #1 had not been given.

On 5/30/2019, RCS Investigator A interviewed Staff D by telephone. Staff D reported there was some delay getting the medications and prep solution from the pharmacy and they were picked up at 6:00pm "the day before" (1D/2019). (Pharmacy records revealed the medications were picked up on 2/25/2019 at 3:40pm). Staff D stated the staff working the night before the procedure (Staff F and Staff G) were "very competent" and "dedicated". Staff D believed Staff F and Staff G would document the physician orders on the MAR. Staff D stated they got busy and did not think to write the orders on the MAR themselves and reiterated they believed Staff F and Staff G would write the orders on the MAR and stated it was just good to have the medications in the house. Staff D then stated technically, Staff E was supposed to write the medications on the MAR as they picked them up from the pharmacy.

On 6/3/2019, RCS Investigator A interviewed Staff E. They stated they delivered Client #1's colonoscopy preparation medication to the home. Staff E stated, "I goofed up and didn't put meds on the MAR". Staff E stated they did not think about putting the new medications on the MAR until they were questioned about why they did not and "it's my bad". Staff E reported if a medication came into a client's home, they were supposed to write the new medications on the

paper MAR.

Review of personnel documents provided by Staff Q on 6/11/2019 found the following staff corrective/disciplinary actions:
-On 4/19/2019, Staff G terminated due to "violation of the medication administration policy".
-On 4/25/2019, Staff F received a final warning for violations of the medication administration policy, including not verifying the medications on the MAR and failing to ensure the six rights of medication administration.
-On 6/7/2019, Staff D received a written warning for not ensuring the medications were added to the MAR.
-On 6/10/2019, Staff E received a written warning for not adding the medications to the MAR after picking them up at the pharmacy and bringing them to Client #1's home.

This is a repeat deficiency previously cited on 10/18/2018 and 12/14/2018.

Plan of Correction: Date Completed: